

DEPENDENCY

§ 436.510 Determination of dependency.

For families with dependent children who are not receiving AFDC, the agency must use the definitions and procedures used under the State's AFDC plan to determine whether—

(a) An individual is a dependent child because he is deprived of parental support or care; and

(b) An individual is an eligible member of a family with dependent children.

[43 FR 45218, Sept. 29, 1978, as amended at 58 FR 4936, Jan. 19, 1993]

AGE

§ 436.520 Age requirements for the aged.

The agency must not impose an age requirement of more than 65 years.

[58 FR 4936, Jan. 19, 1993]

§ 436.522 Determination of age.

(a) In determining age, the agency must use the common law method (under which an age is reached the day before the anniversary of birth) or the popular usage method (under which a specific age is reached on the anniversary of birth), whichever is used under the corresponding State plan for OAA, AFDC, AB, APTD, or AABD.

(b) The agency may use an arbitrary date, such as July 1, for determining an individual's age if the year, but not the month, of his birth is known.

[58 FR 4936, Jan. 19, 1993]

BLINDNESS

§ 436.530 Definition of blindness.

(a) *Definition.* The agency must use the definition of blindness that is used in the State plan for AB or AABD.

(b) *State plan requirement.* The State plan must contain the definition of blindness, expressed in ophthalmic measurements.

§ 436.531 Determination of blindness.

In determining blindness—

(a) A physician skilled in the diseases of the eye or an optometrist, whichever the individual selects, must examine

him, unless both of the applicant's eyes are missing;

(b) The examiner must submit a report of examination to the Medicaid agency; and

(c) A physician skilled in the diseases of the eye (for example, an ophthalmologist or an eye, ear, nose, and throat specialist) must review the report and determine on behalf of the agency—

(1) Whether the individual meets the definition of blindness; and

(2) Whether and when reexaminations are necessary for periodic redeterminations of eligibility, as required under § 435.916 of this subchapter. Blindness is considered to continue until the reviewing physician determines that the recipient's vision no longer meets the definition.

[43 FR 45218, Sept. 29, 1978, as amended at 44 FR 17939, Mar. 23, 1979]

DISABILITY

§ 436.540 Definition of disability.

(a) *Definition.* The agency must use the definition of permanent and total disability that is used in the State plan for APTD or AABD. (See 45 CFR 233.80(a)(1) for the Federal recommended definition of permanent and total disability.)

(b) *State plan requirement.* The State plan must contain the definition of permanent and total disability.

§ 436.541 Determination of disability.

(a) *Basic requirements.* (1) At a minimum, the agency must use the review team, information, and evidence requirements specified in paragraph (b) through (d) of this section in making a determination of disability.

(2) If the requirements or determining disability under the State's APTD or AABD program are more restrictive than the minimum requirements specified in this section, the agency must use the requirements applied under the APTD or AABD program.

(b) The agency must obtain a medical report and a social history for individuals applying for Medicaid on the basis of disability. The medical report must include a diagnosis based on medical evidence. The social history must contain enough information to enable the agency to determine disability.

(c) A physician and social worker, qualified by professional training and experience, must review the medical report and social history and determine on behalf of the agency whether the individual meets the definition of disability. The physician must determine whether and when reexaminations will be necessary for periodic re-determinations of eligibility as required under § 435.916 of this subchapter.

(d) In subsequently determining disability, the physician and social worker must review reexamination reports and the social history and determine whether the individual continues to meet the definition. Disability is considered to continue until this determination is made.

[54 FR 50762, Dec. 11, 1989]

Subpart G—General Financial Eligibility Requirements and Options

§ 436.600 Scope.

This subpart prescribes:

(a) General financial requirements and options for determining the eligibility of both categorically needy and medically needy individuals specified in subparts B, C, and D of this part. Subparts H and I of this part prescribe additional financial requirements.

(b) [Reserved]

[58 FR 4936, Jan. 19, 1993, as amended at 59 FR 43053, Aug. 22, 1994]

§ 436.601 Application of financial eligibility methodologies.

(a) *Definitions.* For purposes of this section, *cash assistance financial methodologies* refers to the income and resources methodologies of the OAA, AFDC, AB, APTD, and AABD programs.

(b) *Basic rule for use of cash assistance methodologies.* Except as specified in paragraphs (c) and (d) of this section, in determining financial eligibility of individuals as categorically and medically needy, the agency must apply the cash assistance financial methodologies and requirements of the cash assistance program that is most closely categorically related to the individual's status.

(c) *Financial responsibility of relatives.* The agency must use the requirements for financial responsibility of relatives specified in § 436.602.

(d) *Use of less restrictive methodologies than under cash assistance program.* (1) At State option, and subject to the conditions of paragraphs (d)(2) through (d)(5) of this section, the agency may apply income and resource methodologies that are less restrictive than the cash assistance methodologies in determining financial eligibility of the following groups:

(i) Qualified pregnant women and children under the mandatory categorically needy group under § 436.120;

(ii) Low-income pregnant women, infants, and children specified in section 1902(a)(10)(i) (IV), (VI), and (VII) of the Act;

(iii) Qualified Medicare beneficiaries specified in sections 1902(a)(10)(E) and 1905(p) of the Act;

(iv) Optional categorically needy individuals under groups established under subpart C of this part and section 1902(a)(10)(A)(ii) of the Act; and

(v) Medically needy individuals under groups established under subpart D of this part and section 1902(a)(10)(C)(i)(III) of the Act.

(2) The income and resource methodologies that an agency elects to apply to groups of individuals under paragraph (c)(1) of this section may be less restrictive, but no more restrictive, than:

(i) For groups of aged, blind, and disabled individuals, the SSI methodologies; or

(ii) For all other groups, the methodologies under the State plan most closely categorically related to the individual's status.

(3) A financial methodology is considered to be no more restrictive if, by using the methodology, additional individuals may be eligible for Medicaid and no individuals who are otherwise eligible are by use of that methodology made ineligible for Medicaid.

(4) The less restrictive methodology applied under this section must be comparable for all persons within each category of assistance (aged, or blind, or disabled, or AFDC-related) within each eligibility group. For example, if